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Vermont's All-Payer ACO Model – GMCB's role

April 9th, 2021

Green Mountain Care Board

All Payer ACO Model Agreement

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What is the APM Agreement? A contract between the state of Vermont (AHS, GMCB, Governor) and the Centers for Medicare and Medicaid (CMS) that…

1. Allows Medicare to join other Vermont payers in Vermont's health care reform efforts— by providing the opportunity to pay ACOs differently than fee-for-service.

2. Holds the state of Vermont accountable to curbing health care cost growth and improving quality of care and population health outcomes. Vermont is also accountable for increasing participation in the model over the life of the agreement (scale).

All Payer ACO Model Agreement

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Addressing health care spending growth by changing how Vermont pays for and deliver health care:

1. Set a budget for the health care system instead of paying for each service performed (fee-for-service), regardless of quality or outcomes.

2. Tie the budget to the quality of care delivered and improved health outcomes.

Vermont's All-Payer ACO Model in Health Care Reform

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1. Health Care Financing

2. Health Care Coverage

3. Payment Reform – Curb Health Care Cost Growth

4. Delivery System Reform – Improve Quality and Population Health

Measuring Vermont's Progress per APM Agreement

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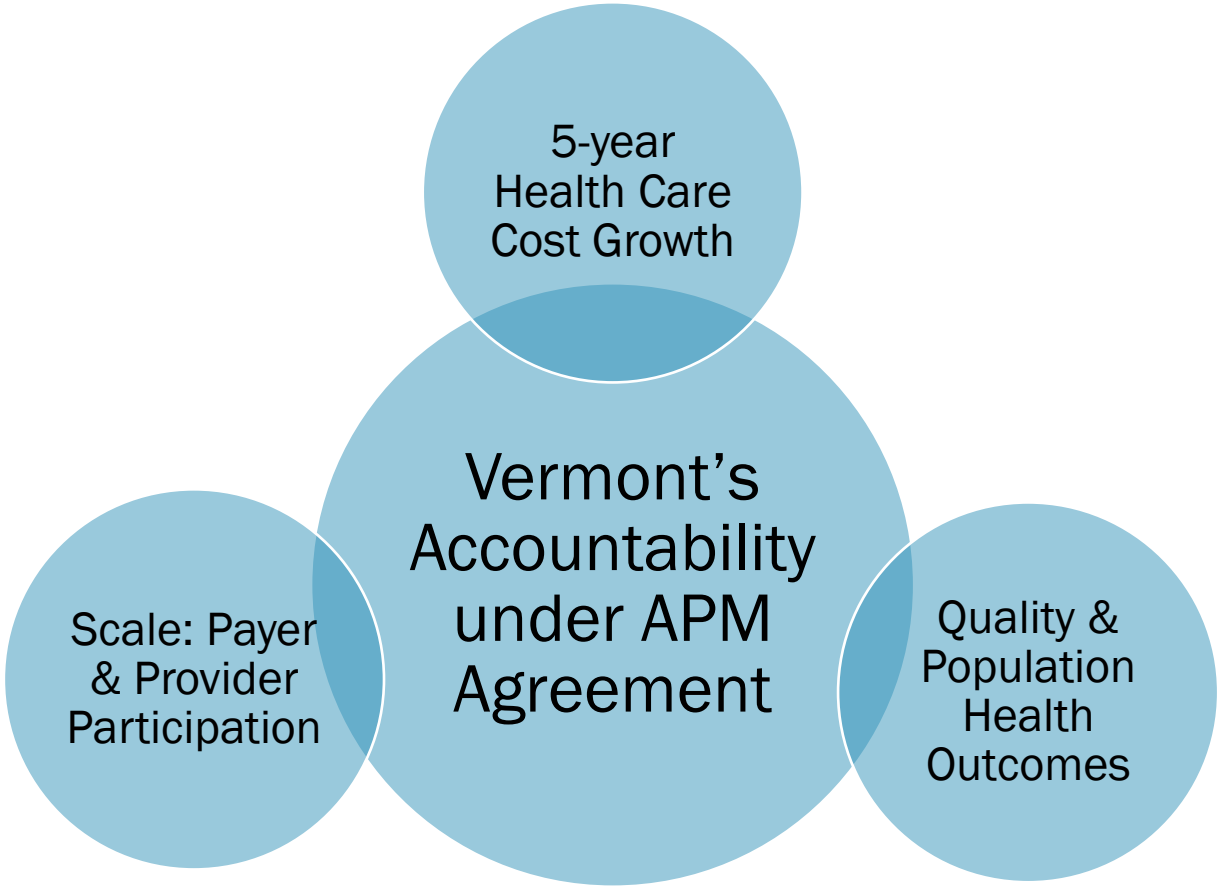

Measuring Vermont's Progress per APM Agreement

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Health Care Cost Growth

Tracks per person spending on certain health care services known as the Total Cost of Care (TCOC).

Measures spending growth for **statewide all-payer** and **Medicare** populations:

1. Is all-payer spending on track to be less than 3.5% or 4.3% over the life of the agreement?
2. Is Vermont's Medicare spending more than 0.2% below the national average

Scale: Payer & Provider Participation

1. Assess alignment across **ACO-payer** programs and determine if scale qualifying

2. Track **providers** participating in qualifying programs

3. Measure scale by determining which **Vermonters "attribute"**: who is covered under a qualifying payer-program and has an established relationship with a participating provider?

Quality & Population Health Outcomes

Population health measures:

1. Improve access to primary care
2. Reduce deaths due to suicide and drug overdose
3. Reduce the prevalence and morbidity of chronic disease

22 Quality measures expected to drive population health:

1. Health delivery system quality targets
2. Process milestones

Measuring progress toward goals of Vermont's All-Payer Model Agreement

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Scale: Payer & Provider Participation Growth

Medicare scale has grown 37% between 2018 and 2020, but is still short of the target, 44% vs 79%.

All-Payer scale has grown 103% between 2018 and 2020, but is still short of the target, 42% vs 58%.

Quality & Population Health Outcomes (2019)

Making progress on **5/6** Population Health Outcomes Targets

Moving toward achievement of **7/8*** Healthcare Delivery System Quality Targets

Making progress toward **5/6*** Process Milestones

*Two data points are currently unavailable due to the PHE

Health Care Cost Growth (2019)

2017 through 2019 compounded annual growth: **4.6%**

2018: 4.1% All-Payer Growth

2019: 5.2% All-Payer Growth

GMCB's role in the All Payer ACO Model Agreement

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1. Proxy for Medicare
    1. Establish health care spending targets, the mechanism for constraining fee for service health care cost growth
    2. Along with co-signatories, recommends program design modifications to the Medicare ACO initiative to better align with other Vermont health care reform efforts.
2. Ensure Regulatory Alignment
3. Statewide Health Care Data, Reporting, and Analytics

Reporting to CMS

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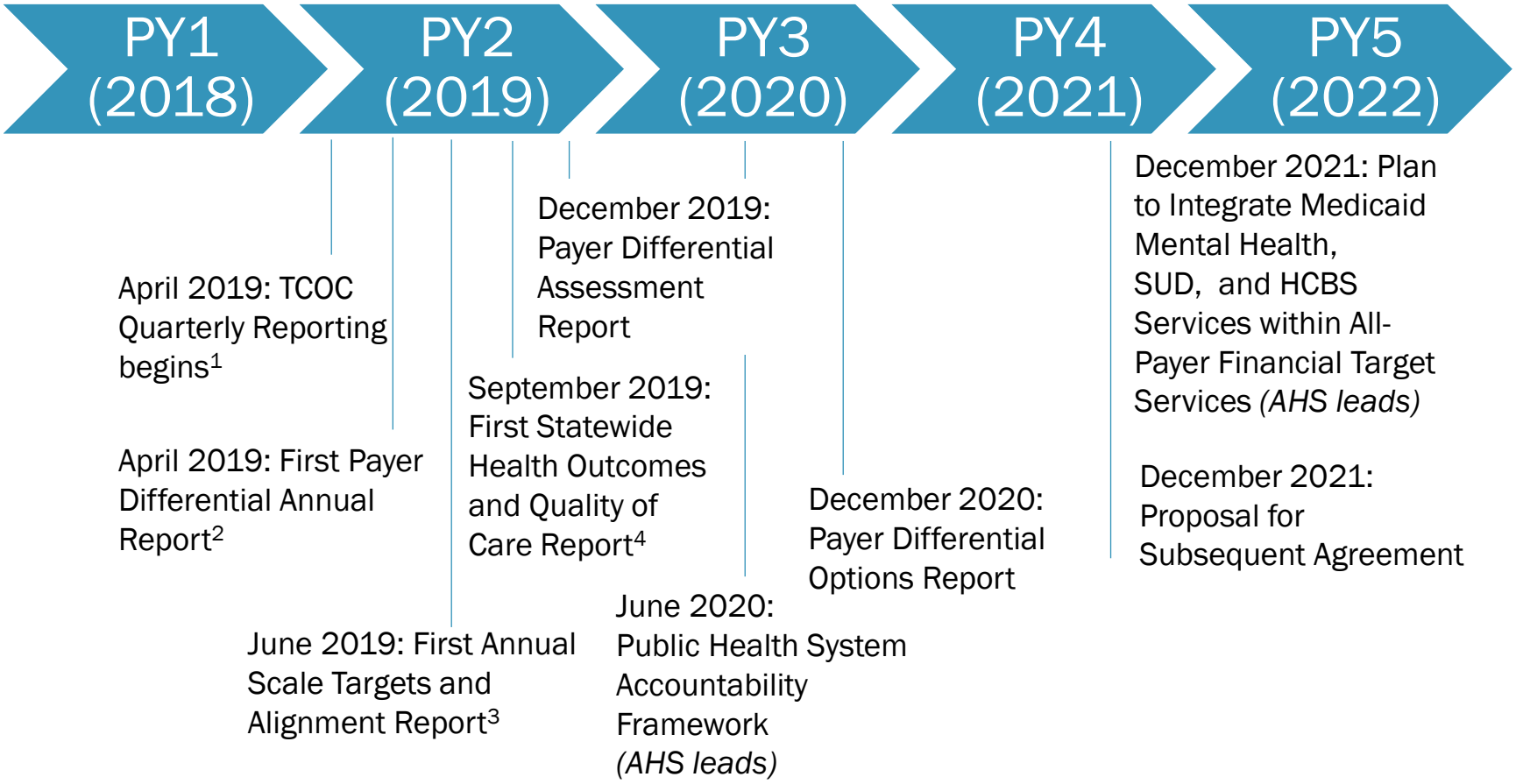

[1] Submitted quarterly (reports produced approximately 9 months following final date of service); annual reports completed as data allow. [2] Submitted annually on 4/1. [3] Submitted annually on 6/30. [4] Submitted annually on 12/30, or as data allow.

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Questions?

Key Terms

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- **Center for Medicare and Medicaid Innovation (CMMI)** - a division of U.S. Health and Human Services in charge of innovation, primarily focused on Medicare.
  - https://innovation.cms.gov/
- **State-Federal Agreement** - an agreement between CMMI and a state to create a geographically based payment and delivery reform model
- **Waiver** - an agreement between CMMI and the provider organization, which allows the provider to operate under different legal requirements than what is included in Medicare statute, rules, and guidance.

What authority does CMMI have?

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Sec. 1115A of SSA allows CMMI to:

1. Establish new payment models for Medicare, including through agreements with states (e.g. MD, PA, VT)
2. Waive some, but not all, federal requirements when tied directly to the payment/delivery system reform model
3. Increase benefits for Medicare beneficiaries, as long as this results in an overall savings to the Medicare Trust Fund

What authority is not provided?

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Under current law, CMMI cannot:

1. **Change** eligibility for Medicare;
2. **Reduce** benefits for Medicare beneficiaries;
3. **Change** cost-sharing for Medicare beneficiaries;
4. *Probably*, **include** prescription drugs in the model, due Part D benefits being administered by private companies.

Section 1115A is only Medicare focused. Agreements with other federal agencies are not included (e.g. Medicaid, Vermont Health Connect, etc)

Federal Requirements for Approval

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1. The model must save the Medicare program money while maintaining or increasing quality over the course of the model.
2. Agreements tend to span 5 years, with option for renewal
3. CMMI will take the following into consideration when approving a model:
    1. Monitoring and updating care plans
    2. “Patient centered”
    3. In-person contact with individuals
    4. HIT used
    5. Care coordination
    6. Team-based approach
    7. Information sharing